UTAH COUNTY HEALTH DEPARTMENT

YOU WILL RECEIVE A RESPONSE IN 2-3 BUSINESS DAYS FROM THE TIME WE RECEIVE YOUR FORM

PATIENT NAME: _____
Last First MI Maiden or Other Name

DATE OF BIRTH: _____

☐ **I authorize the release of information held by the Utah County Health Department (UCHD) to:**

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____ EMAIL: _____

☐ **I authorize the release of information held by _____ to the Utah County Health Department (UCHD).**

Please send material to: Utah County Health Department
151 S University Ave #1610
Provo, UT 84601

Phone: 801-851-7025
Fax: 801-851-7055
Email: shirleyo@UtahCounty.gov

INFORMATION TO BE RELEASED:

	DATES		DATES
☐ History and physical exam	_____	☐ STD	_____
☐ Nursing Notes	_____	☐ HIV related information	_____
☐ X-ray reports	_____	☐ Incident/Short encounters	_____
☐ Immunizations	_____	☐ Other: _____	_____
☐ Cholesterol	_____		

PURPOSE OF DISCLOSURE:

☐ Changing Physicians	☐ Consultation/second opinion	☐ Continuing Care	☐ Personal
☐ School	☐ Insurance	☐ Workers Compensation	☐ Other (please specify):
☐ Legal			_____

1. I understand that this authorization will expire **90 days** after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and that it will be effective on the date written notice is received (except to the extent of action taken prior to receiving the written notice).
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. By authorizing this release of information, I understand that my health care and payment for my health care will not be affected.
5. I understand that I may have a copy of the information described on this form and a copy of this form after I have signed it.
6. I have been informed that Utah County Health Department will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

_____ **OR** _____ _____

SIGNATURE OF PATIENT PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____

PLEASE PRINT NAME DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____